AMENDED IN SENATE APRIL 11, 2005

SENATE BILL No. 526

Introduced by Senator Alquist

February 18, 2005

An act to amend Sections 1324.25, 1420, 1424, and 1599.1 of, and to repeal Section 1419 of, the Health and Safety Code, and to amend Sections 14124.10 and 14126.023 of the Welfare and Institutions Code, relating to long-term health care facilities.

LEGISLATIVE COUNSEL'S DIGEST

SB 526, as amended, Alquist. Long-term health care.

Existing law provides for the licensure and regulation by the State Department of Health Services of health care facilities, including long-term health care facilities.

Existing law establishes procedures to be followed when the department receives a written or oral complaint about a long-term health care facility.

Existing law requires the department to establish a centralized consumer response unit within the Licensing and Certification Division of the department to respond to consumer inquiries and complaints.

This bill would repeal this provision. The bill would, instead, require, by January 1, 2007, the department to establish and operate a dedicated complaint response unit in each district office of the Licensing and Certification Division of the department to respond to consumer inquiries and complaints. The bill would require the department to submit a report to the Legislature, on or before January 1, 2006, about the necessary workforce and projected costs associated with the dedicated complaint response units. The bill would make other changes to the complaint procedures.

Existing law provides for the imposition of a quality assurance fee on each skilled nursing facility, with some exemptions, to be administered by the director and deposited in the State Treasury. Existing law requires that funds assessed pursuant to these provisions be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and support facility quality improvement efforts in, licensed skilled nursing facilities. Existing law provides that these provisions are to be implemented as long as 2 conditions are met, including federal approval, specifies 4 circumstances under which these provisions would become inoperative, makes these provisions inoperative on July 1, 2008, and repeals them on January 1, 2009.

This bill would provide that the dedicated complaint response unit provisions provided under the bill shall only be implemented to the extent that the provisions imposing the quality assurance fee for skilled nursing facilities are implemented and operative. The bill would provide that the quality assurance fee assessment shall be available to support the costs of implementing and operating the complaint response units established under the bill.

Existing law ~~precribes~~ *prescribe* procedures for the issuance of a citation, classified according to the nature of the violation, and the imposition of a civil penalty against a long-term health care facility. Existing law provides that a Class "A" violation is a violation that the department determines presents either an imminent danger or substantial probability that death or serious harm to the patients or residents of the facility would result from the violation.

This bill would provide, instead, that a Class "A" violation is a violation that the department determines presents or involves, in addition to the situations presented, a nonconsensual sexual encounter between a patient or resident of the facility and any staff member currently employed by the same facility.

Existing law requires that written policies and procedures of a skilled nursing and intermediate care facility ensure that each patient admitted to the facility has prescribed rights.

This bill would add to these rights, among others, reasonable accommodation of individual needs and preferences, the right to choose an attending physician, the right to discharge oneself, bed hold options for hospitalized residents, and transfer and discharge rights.

Existing law prohibits a long-term health care facility that participates as a provider under the Medi-Cal program from

discriminating against a Medi-Cal patient on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program.

This bill, instead, would prohibit discrimination under this provision against a Medi-Cal resident or prospective Medi-Cal resident.

This bill would prohibit each skilled nursing facility, with exceptions, from discriminating, on the basis of source of payment, against a current or prospective Medi-Cal beneficiary who seeks admission. The bill would require that all applicants for admission be admitted in the order in which they first request admission, with exceptions, and would establish additional requirements of a skilled nursing facility to provide certain notice, provide receipts of requests seeking admission, and maintain a dated list of applications. The bill would authorize the department to decrease the daily Medi-Cal reimbursement rate to a long-term health care facility for one year for a violation of this provision.

Existing law requires the department to establish the minimum number of equivalent nursing hours per patient required in skilled nursing and intermediate care facilities.

Existing law provides for the Medi-Cal program, which is administered by the department and under which qualified low-income persons receive health care benefits. Existing law provides for a Medi-Cal long-term care reimbursement methodology, that includes a facility-specific ratesetting system. Existing law provides for a labor-driven operating allocation under the methodology.

This bill would provide that the labor-driven operating allocation shall not be paid to facilities that, on an annual basis, fail to comply with the minimum staffing hours per patient required in skilled nursing and intermediate care facilities. The bill would require a skilled nursing facility to submit electronic payroll records to the department on a quarterly basis to document labor costs. The bill would require the department, on or before July 1, 2006, to devise and implement a uniform system for collecting and evaluating payroll data. The bill would require the administrator of the facility to sign and certify the accuracy of the payroll records, under penalty of perjury. Because this requirement would expand the scope of the crime of perjury, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. *(a)* The Legislature finds and declares all of the following:

~~(a)~~

(1) Over 14,000 oral and written complaints are filed each year with the Licensing and Certification Division of the State Department of Health Services.

~~(b)~~

(2) Currently, the department is required to respond to all complaints within statutory timelines with an onsite investigation to determine if the complaint is substantiated.

~~(c)~~

(3) As a result of the high volume of complaints, the lack of coordinated efforts among district offices of the Licensing and Certification Division of the department, and the lack of adequate staff, complaints are frequently not resolved within statutory timelines, resulting in violation of state laws, consumer dissatisfaction and frustration, and an estimated 73 percent of complaints being found to be unsubstantiated as a result of inadequate investigations.

(b) The Legislature also finds and declares both of the following:

(1) That the State Department of Health Services is required to inspect and investigate long-term health care facilities for compliance with state and federal laws and regulations pursuant to, at a minimum, Section 1423 of the Health and Safety Code.

(2) That changes made by this act to Section 1599.1 of the Health and Safety Code and Section 14124.10 of the Welfare and Institutions Code incorporate into state law requirements set forth under federal law, which the department already has a

responsibility to enforce and these changes should not result in additional enforcement costs.

SEC. 2. Section 1324.25 of the Health and Safety Code is amended to read:

1324.25. The funds assessed pursuant to this article shall be available to enhance federal financial participation in the Medi-Cal program, to provide additional reimbursement to, and to support facility quality improvement efforts in, licensed skilled nursing facilities, and to support the costs of implementing and operating the complaint response units established under subdivision (a) of Section 1420.

SEC. 3. Section 1419 of the Health and Safety Code is repealed.

SEC. 4. Section 1420 of the Health and Safety Code is amended to read:

1420. (a) (1) By January 1, 2007, the department shall establish and operate a dedicated complaint response unit in each district office of the Licensing and Certification Division of the department to respond to consumer inquiries and complaints. Each complaint unit shall include a sufficient number of appropriately trained and qualified staff necessary to ensure thorough investigation of complaints and facility reports of suspected abuse, neglect, and unusual occurrence within the timelines established under this section.

(2) Not later than January 1, 2006, the department shall provide a report to the Legislature that includes a review of the appropriate workforce necessary to implement the dedicated complaint response units and the projected costs of implementation.

(3) The department shall demonstrate good faith efforts to comply with the requirements of this section, including hiring any additional staff necessary. The department shall develop a plan for full compliance by January 1, 2007.

(4) The requirements of this subdivision shall only be implemented to the extent that Article 7.6 (commencing with Section 1324.20) of Chapter 2 is implemented and operative.

(5) Nothing in this section shall preclude the department from taking any and all enforcement actions available under state and federal law.

(b) (1) Upon receipt of a written or oral complaint, the department shall assign an inspector to make a preliminary review of the complaint and shall notify the complainant within two working days of the receipt of the complaint of the name of the inspector. Unless the department determines that the complaint is willfully intended to harass a licensee or is without any reasonable basis, it shall make an onsite inspection or investigation within 10 working days of the receipt of the complaint. In any case in which the complaint involves a threat of imminent danger of death or serious bodily harm, the department shall make an onsite inspection or investigation within 24 hours of the receipt of the complaint. In any event, the complainant shall be promptly informed, in no case later than 10 working days of receipt of the complaint, of the department's proposed course of action and of the opportunity to accompany the inspector on the inspection or investigation of the facility. Upon the request of either the complainant or the department, the complainant or his or her representative, or both, may be allowed to accompany the inspector to the site of the alleged violations during his or her tour of the facility, unless the inspector determines that the privacy of any patient would be violated thereby.

(2) When conducting an onsite inspection or investigation pursuant to this section, the department shall collect and evaluate all available evidence and may issue a citation based upon, but not limited to, all of the following:

(A) Observed conditions.

(B) Statements of witnesses.

(C) Facility records.

(3) A final determination as a result of the inspection or investigation shall be completed within 90 days of receipt of the complaint by the department.

(4) Within 10 working days of the completion of the complaint investigation, the department shall notify the complainant and licensee in writing of the department's determination as a result of the inspection or investigation.

(c) Upon being notified of the department's determination as a result of the inspection or investigation, a complainant who is dissatisfied with the state department's determination, regarding a matter which would pose a threat to the health, safety, security,

welfare, or rights of a resident, shall be notified by the department of the right to an informal conference, as set forth in this section. The complainant may, within 15 business days after receipt of the notice, notify the director in writing of his or her request for an informal conference. The informal conference shall be held with the designee of the director for the county in which the long-term health care facility which is the subject of the complaint is located. The long-term health care facility may participate as a party in this informal conference. The director's designee shall notify the complainant and licensee of his or her determination within 10 working days after the informal conference and shall apprise the complainant and licensee in writing of the appeal rights provided in subdivision (d).

(d) If the complainant is dissatisfied with the determination of the director's designee in the county in which the facility is located, the complainant may, within 15 days after receipt of this determination, notify in writing the Deputy Director of the Licensing and Certification Division of the department, who shall assign the request to a representative of the Complainant Appeals Unit for review of the facts that led to both determinations. As a part of the Complainant Appeals Unit's independent investigation, and at the request of the complainant, the representative shall interview the complainant in the district office where the complaint was initially referred. Based upon this review, the Deputy Director of the Licensing and Certification Division of the department shall make his or her own determination and notify the complainant and the facility within 30 days.

(e) Any citation issued as a result of a conference or review provided for in subdivision (c) or (d) shall be issued and served upon the facility within three working days of the final determination, unless the licensee agrees in writing to an extension of this time. Service shall be effected either personally or by registered or certified mail. A copy of the citation shall also be sent to each complainant by registered or certified mail.

(f) A miniexit conference shall be held with the administrator or his or her representative upon leaving the facility at the completion of the investigation to inform him or her of the status of the investigation. The department shall also state the items of noncompliance and compliance found as a result of a complaint

and those items found to be in compliance, provided the disclosure maintains the anonymity of the complainant. In any matter in which there is a reasonable probability that the identity of the complainant will not remain anonymous, the department shall also notify the facility that it is unlawful to discriminate or seek retaliation against a resident, employee, or complainant.

(g) For purposes of this section, "complaint" means any oral or written notice to the department, other than a report from the facility of an alleged violation of applicable requirements of state or federal law or any alleged facts that might constitute such a violation.

SEC. 5. Section 1424 of the Health and Safety Code is amended to read:

1424. Citations issued pursuant to this chapter shall be classified according to the nature of the violation and shall indicate the classification on the face thereof.

(a) In determining the amount of the civil penalty, all relevant facts shall be considered~~,~~ including, but not limited to, the following:

(1) The probability and severity of the risk that the violation presents to the patient's or resident's mental and physical condition.

(2) The patient's or resident's medical condition.

(3) The patient's or resident's mental condition and his or her history of mental disability or disorder.

(4) The good faith efforts exercised by the facility to prevent the violation from occurring.

(5) The licensee's history of compliance with regulations.

(b) Relevant facts considered by the department in determining the amount of the civil penalty shall be documented by the department on an attachment to the citation and available in the public record. This requirement shall not preclude the department or a facility from introducing facts not listed on the citation to support or challenge the amount of the civil penalty in any proceeding set forth in Section 1428.

(c) (1) Class "AA" violations are violations that meet the criteria for a class "A" violation and that the ~~state~~ department determines to have been a direct proximate cause of death of a patient or resident of a long-term health care facility. Except as provided in Section 1424.5, a class "AA" citation is subject to a

civil penalty in the amount of not less than five thousand dollars ($5,000) and not exceeding twenty-five thousand dollars ($25,000) for each citation. In any action to enforce a citation issued under this subdivision, the ~~state~~ department shall prove all of the following:

(A) The violation was a direct proximate cause of death of a patient or resident.

(B) The death resulted from an occurrence of a nature that the regulation was designed to prevent.

(C) The patient or resident suffering the death was among the class of persons for whose protection the regulation was adopted.

(2) If the ~~state~~ department meets the burden of proof required under paragraph (1), the licensee shall have the burden of proving that the licensee did what might reasonably be expected of a long-term health care facility licensee, acting under similar circumstances, to comply with the regulation. If the licensee sustains this burden, then the citation shall be dismissed.

(3) Except as provided in Section 1424.5, for each class "AA" citation within a 12-month period that has become final, the ~~state~~ department shall consider the suspension or revocation of the facility's license in accordance with Section 1294. For a third or subsequent class "AA" citation in a facility within that 12-month period that has been sustained following a citation review conference, the ~~state~~ department shall commence action to suspend or revoke the facility's license in accordance with Section 1294.

(d) (1) Class "A" violations are violations that the ~~state~~ department determines present or involve any of the following:

(A) Imminent danger that death or serious harm to the patients or residents of the long-term health care facility would result therefrom.

(B) Substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom.

(C) A nonconsenual sexual encounter between a patient or resident of the long-term health care facility and any staff member currently employed by the same facility.

(2) A physical condition or one or more practices, means, methods, or operations in use in a long-term health care facility may constitute a class "A" violation.

(3) The condition or practice constituting a class "A" violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the ~~state~~ department, is required for correction. Except as provided in Section 1424.5, a class "A" citation is subject to a civil penalty in an amount not less than one thousand dollars ($1,000) and not exceeding ten thousand dollars ($10,000) for each and every citation.

(4) If the ~~state~~ department establishes that a violation occurred, the licensee shall have the burden of proving that the licensee did what might reasonably be expected of a long-term health care facility licensee, acting under similar circumstances, to comply with the regulation. If the licensee sustains this burden, then the citation shall be dismissed.

(e) (1) Class "B" violations are violations that the ~~state~~ department determines have a direct or immediate relationship to the health, safety, or security of long-term health care facility patients or residents, other than class "AA" or "A" violations. Unless otherwise determined by the ~~state~~ department to be a class "A" violation pursuant to this chapter and rules and regulations adopted pursuant thereto, any violation of a patient's rights as set forth in Sections 72527 and 73523 of Title 22 of the California Code of Regulations, that is determined by the ~~state~~ department to cause or under circumstances likely to cause significant humiliation, indignity, anxiety, or other emotional trauma to a patient is a class "B" violation. A class "B" citation is subject to a civil penalty in an amount not less than one hundred dollars ($100) and not exceeding one thousand dollars ($1,000) for each and every citation. A class "B" citation shall specify the time within which the violation is required to be corrected. If the ~~state~~ department establishes that a violation occurred, the licensee shall have the burden of proving that the licensee did what might reasonably be expected of a long-term health care facility licensee, acting under similar circumstances, to comply with the regulation. If the licensee sustains this burden, then the citation shall be dismissed.

(2) In the event of any citation under this paragraph, if the ~~state~~ department establishes that a violation occurred, the licensee shall have the burden of proving that the licensee did what might reasonably be expected of a long-term health care facility licensee, acting under similar circumstances, to comply

with the regulation. If the licensee sustains this burden, then the citation shall be dismissed.

(f) (1) Any willful material falsification or willful material omission in the health record of a patient of a long-term health care facility is a violation.

(2) "Willful material falsification," as used in this section, means any entry in the patient health care record pertaining to the administration of medication, or treatments ordered for the patient, or pertaining to services for the prevention or treatment of decubitus ulcers or contractures, or pertaining to tests and measurements of vital signs, or notations of input and output of fluids, that was made with the knowledge that the records falsely reflect the condition of the resident or the care or services provided.

(3) "Willful material omission," as used in this section, means the willful failure to record any untoward event that has affected the health, safety, or security of the specific patient, and that was omitted with the knowledge that the records falsely reflect the condition of the resident or the care or services provided.

(g) Except as provided in subdivision (a) of Section 1425.5, a violation of subdivision (f) may result in a civil penalty not to exceed ten thousand dollars ($10,000), as specified in paragraphs (1) to (3), inclusive.

(1) The willful material falsification or willful material omission is subject to a civil penalty of not less than two thousand five hundred dollars ($2,500) or more than ten thousand dollars ($10,000) in instances where the health care record is relied upon by a health care professional to the detriment of a patient by affecting the administration of medications or treatments, the issuance of orders, or the development of plans of care. In all other cases, violations of this subdivision are subject to a civil penalty not exceeding two thousand five hundred dollars ($2,500).

(2) (A) Where the penalty assessed is one thousand dollars ($1,000) or less, the violation shall be issued and enforced, except as provided in this subdivision, in the same manner as a class "B" violation, and shall include the right of appeal as specified in Section 1428. Where the assessed penalty is in excess of one thousand dollars ($1,000), or for skilled nursing facilities or intermediate care facilities as specified in paragraphs

(1) and (2) of subdivision (a) of Section 1418, in excess of two thousand dollars ($2,000), the violation shall be issued and enforced, except as provided in this subdivision, in the same manner as a class "A" violation, and shall include the right of appeal as specified in Section 1428.

(B) Nothing in this section shall be construed as a change in previous law enacted by Chapter 11 of the Statutes of 1985 relative to this paragraph, but merely as a clarification of existing law.

(3) Nothing in this subdivision shall preclude the ~~state~~ department from issuing a class "A" or class "B" citation for any violation that meets the requirements for that citation, regardless of whether the violation also constitutes a violation of this subdivision. However, no single act, omission, or occurrence may be cited both as a class "A" or class "B" violation and as a violation of this subdivision.

(h) Where the licensee has failed to post the notices as required by Section 9718 of the Welfare and Institutions Code in the manner required under Section 1422.6, the ~~state~~ department shall assess the licensee a civil penalty in the amount of one hundred dollars ($100) for each day the failure to post the notices continues. Where the total penalty assessed is less than two thousand dollars ($2,000), the violation shall be issued and enforced in the same manner as a class "B" violation, and shall include the right of appeal as specified in Section 1428. Where the assessed penalty is equal to or in excess of two thousand dollars ($2,000), the violation shall be issued and enforced in the same manner as a class "A" violation and shall include the right of appeal as specified in Section 1428. Any fines collected pursuant to this subdivision shall be used to fund the costs incurred by the California Department of Aging in producing and posting the posters.

(i) The director shall prescribe procedures for the issuance of a notice of violation with respect to violations having only a minimal relationship to patient safety or health.

(j) The department shall provide a copy of all citations issued under this section to the affected residents whose treatment was the basis for the issuance of the citation, to the affected residents' designated family member or representative of each of the

residents, and to the complainant if the citation was issued as a result of a complaint.

(k) Nothing in this section is intended to change existing statutory or regulatory requirements governing the ability of a licensee to contest a citation pursuant to Section 1428.

(*l*) The department shall ensure that district office activities performed under Sections 1419 to 1424, inclusive, are consistent with the requirements of these sections and all applicable laws and regulations. To ensure the integrity of these activities, the department shall establish a statewide process for the collection of postsurvey evaluations from affected facilities.

SEC. 6. Section 1599.1 of the Health and Safety Code is amended to read:

1599.1. Written policies regarding the rights of residents shall be established and shall be made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. Those policies and procedures shall ensure that each resident admitted to the facility has the following rights and is notified of the following facility obligations, in addition to those specified by regulation:

(a) The facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility.

(b) Each resident shall show evidence of good personal hygiene, be given care to prevent bedsores, and measures shall be used to prevent and reduce incontinence for each patient.

(c) The facility shall provide food of the quality and quantity to meet the residents' needs in accordance with physicians' orders.

(d) The facility shall provide an activity program staffed and equipped to meet the needs and interests of each resident and to encourage self-care and resumption of normal activities. Residents shall be encouraged to participate in activities suited to their individual needs.

(e) The facility shall be clean, sanitary, and in good repair at all times.

(f) A nurses' call system shall be maintained in operating order in all nursing units and provide visible and audible signal communication between nursing personnel and residents. Extension cords to each resident's bed shall be readily accessible to residents at all times.

(g) ~~Each~~ *Consistent with federal law, each* resident shall have the right to reside and receive services with reasonable accommodation of individual~~ needs and preferences and to exercise choice about daily routines. This right shall include, but not be limited to, the right to reasonable accommodation of roommate preferences and the right to advance written notice before change of room or roommate.~~ *needs and preferences, except where the health and safety of the individual or other residents would be endangered, and to receive notice before the room or a roommate of the resident in the facility is changed. A resident shall have all of the following rights:*

(1) To choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care.

(2) To interact with members of the community both inside and outside of the facility.

(3) To make choices about aspects of his or her life in the facility that are significant to the resident.

(h) ~~Each~~ *Consistent with federal law, each* resident shall have the right to choose~~ an~~ *a personal* attending physician and other health care providers. For purposes of this subdivision, an "attending physician" means the physician chosen by the resident or resident's representative to be responsible for the medical treatment of the resident in the facility. If a resident does not have~~ an~~ *a personal* attending physician, the facility shall assist the resident in obtaining one.

(i) ~~Each~~ *A* resident shall have the right to discharge himself or herself from the facility. *The exercise of this right is subject to Section 1599.3, which establishes when a resident's rights devolve to an authorized representative.*

(j) Each resident shall have the right to receive long-term health care services in the most integrated setting appropriate. ~~The~~ *Pursuant to Section 1418.81, the* facility shall provide assessment and discharge planning services that are designed to help residents return home or to home-like settings.

(k) (1) If a facility has a significant beneficial interest in an ancillary health service provider or if a facility knows that an ancillary health service provider has a significant beneficial interest in the facility, as provided by subdivision (a) of Section 1323, or if the facility has a significant beneficial interest in another facility, as provided by subdivision (c) of Section 1323,

the facility shall disclose that interest in writing to the resident, or his or her representative, and advise the resident, or his or her representative, that the resident may choose to have another ancillary health service provider, or facility, as the case may be, provide any supplies or services ordered by a member of the medical staff of the facility.

(2) A facility is not required to make any disclosures required by this subdivision to any resident, or his or her representative, if the resident is enrolled in an organization or entity that provides or arranges for the provision of health care services in exchange for a prepaid capitation payment or premium.

(l) (1) A resident of a long-term health care facility who is hospitalized in an acute care hospital has all of the following rights:

(A) To receive written notice at the time of hospitalization explaining his or her right to return to the facility.

(B) To have his or her bed held for up to seven days by giving notice to the facility within 24 hours after being informed of the right to have the bed held, if the resident desires to have his or her bed held.

(C) To be readmitted to the first available bed *in a semiprivate room* at the facility if*, at the time of readmission, the resident requires the services provided by the facility and* the hospitalization exceeds the seven-day bed hold period or the resident ~~does~~ *did* not exercise the bed hold option.

(2) Except as provided in Section 51535.1 of Title 22 of the California Code of Regulations, any resident who exercises the bed hold option shall be liable to pay reasonable charges, not to exceed the resident's daily rate for care in the facility.

(3) If a resident asserts his or her rights to readmission pursuant to bed hold provisions or readmission rights of either state or federal law and the facility refuses to readmit him or her, the resident may appeal the facility's refusal.

(4) The refusal of the facility as described in this subdivision shall be treated as if it were an involuntary transfer under federal law and the rights and procedures that apply to appeals of transfers and discharges of nursing facility residents shall apply to the resident's appeal under this subdivision.

(5) If the resident appeals pursuant to this subdivision, and the resident is eligible under the Medi-Cal program, the resident

shall remain in the hospital and the hospital may be reimbursed at the administrative day rate, pending the final determination of the hearing officer, unless the resident agrees to placement in another facility.

(6) If the resident appeals pursuant to this subdivision, and the resident is not eligible under the Medi-Cal program, the resident shall remain in the hospital if other payment is available, pending the final determination of the hearing officer, unless the resident agrees to placement in another facility.

(7) If the resident is not eligible for participation in the Medi-Cal program and has no other source of payment, the hearing and final determination shall be made within 48 hours.

(m) (1) ~~Each~~ *Consistent with federal law, each* resident shall have all of the transfer and discharge rights described in this subdivision.

(2) For purposes of this subdivision, the following definitions shall apply:

(A) "Facility" means a skilled nursing facility or intermediate care facility, as defined in Section 1250.

(B) "Certified entity" means a Medi-Cal program certified facility, a Medicare Program certified facility, or a Medicare Program certified distinct part.

(C) "Discharge" means movement from a facility to a noninstitutional setting when the discharging facility ceases to be legally responsible for the care of the resident.

(D) "Transfer" means movement from a facility or certified entity to another institution when the legal responsibility for the care of the resident changes from the transferring facility to the receiving institution. A transfer includes movement of a resident from a bed in a certified entity to a bed in an entity that is certified as a different provider or to a bed that is not certified for the Medi-Cal program or the Medicare Program.

(3) The facility shall permit each resident to remain in the facility and not transfer or discharge the resident from the facility, unless one of the following circumstances exist:

(A) The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility.

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility.

(C) The safety of individuals in the facility is endangered.

(D) The health of individuals in the facility would otherwise be endangered.

(E) The resident has failed, after reasonable and appropriate notice, to pay or have paid in his or her behalf, in the case of the Medi-Cal program or the Medicare Program, for a stay at the facility. As specified in Section 14124.7 of the Welfare and Institutions Code, a Medi-Cal certified facility may not discharge a resident who converts to coverage under the Medi-Cal program after admission or who has a Medi-Cal application pending.

(F) The facility ceases to operate.

(4) When the facility transfers or discharges a resident under any of the circumstances set forth in subparagraphs (A) to (E), inclusive, of paragraph (3), the resident's clinical record shall be documented. When transfer or discharge is necessary under subparagraph (A) or (B) of paragraph (3), the documentation shall be made by the resident's physician. When transfer or discharge is necessary under subparagraph (D) of paragraph (3), the documentation shall be made by a physician.

(5) The resident shall have the right to appeal a proposed or completed transfer or discharge. The appeal shall include the right to an informal hearing conducted by the department's administrative hearings and appeals unit prior to the proposed date of transfer or discharge. If the resident files the appeal within 10 days of receipt of the notice described in paragraph (6), the resident shall have the right to remain in the facility until a written determination is made on the appeal.

(6) Before a facility transfers or discharges a resident, the facility shall do all of the following:

(A) Notify the resident and, if known, a family member or legal representative of the resident, of the transfer or discharge and the reasons for the transfer or discharge in writing and in language and a manner the resident, family member, or legal representative understands.

(B) Record the reasons in the resident's clinical record.

(C) Include in the notice the items described in paragraph (8).

(D) Send a copy of the notice to the district office of the department's Licensing and Certification Division and to the local office of the State Long-Term Care Ombudsman.

(7) (A) Except as provided in subparagraph (B), the notice of transfer or discharge required under paragraph (6) shall be made by the facility at least 30 days before the resident is transferred or discharged.

(B) Notice may be made as soon as practicable before transfer or discharge when any of the following conditions exist:

(i) The safety of individuals in the facility would be endangered under subparagraph (C) of paragraph (3).

(ii) The health of individuals in the facility would be endangered under subparagraph (D) of paragraph (3).

(iii) The resident's health improves sufficiently to allow a more immediate transfer or discharge and thus transfer or discharge is authorized under subparagraph (B) of paragraph (3).

(iv) An immediate transfer or discharge is required by the resident's urgent medical needs and thus transfer or discharge is authorized under subparagraph (A) of paragraph (3).

(v) The resident has not resided in the facility for 30 days.

(8) The written notice required under paragraph (6) shall include all of the following:

(A) The reason for transfer or discharge.

(B) The effective date of transfer or discharge.

(C) The location to which the resident will be transferred or discharged.

(D) The following statements:

(i) That the resident has the right to appeal the action to the State Department of Health Services and the name, address, and telephone number of the district office of the Licensing and Certification Division of the department.

(ii) That the facility must permit the resident to remain until an appeal determination is issued if the appeal is filed within 10 days of receipt of the notice.

(iii) That the resident may represent himself or herself or use legal counsel or a relative, friend, or other spokesperson at any appeal hearing.

(iv) That the resident or resident's representative shall be allowed to review, prior to and during the appeal hearing, the

resident's medical records and documents to be used by the facility at any appeal hearing.

(v) That the resident may bring witnesses to any appeal hearing.

(E) The name, address, and telephone number of the local office of the State Long-Term Care Ombudsman.

(F) For nursing facility residents with developmental disabilities or who are mentally ill, the name, address, and telephone number of the protection and advocacy agency described in subdivision (i) of Section 4900 of the Welfare and Institutions Code.

(9) The department shall rescind a proposed transfer or discharge when the notice required in paragraph (6) does not meet the requirements set forth in paragraph (8). A facility that issues an invalid notice or fails to meet the requirements of subparagraph (D) of paragraph (6) is subject to a class B citation.

(10) A facility shall provide sufficient advance preparation and orientation to residents to ensure safe and orderly transfer ~~or discharge from the facility. "Sufficient advance preparation" means the facility takes timely steps to protect the resident from unnecessary and avoidable anxiety and trauma related to the transfer or discharge. The facility shall actively involve the resident and the resident's family in the selection of any new residence or facility. The facility shall ensure that necessary care and services, including appropriate transportation to a new residence or facility, are available upon transfer or discharge. "Orientation" means the facility helps prepare the resident for the move to a new residence or facility by appropriate methods, including trial visits, and thoroughly informs staff at the~~ *or discharge from the facility by performing all of the following:*

(A) Taking timely steps to protect the resident from unnecessary and avoidable anxiety and trauma related to the transfer or discharge.

(B) Actively involving the resident and the resident's family in the selection of any new residence or facility.

(C) Ensuring that necessary care and services, including appropriate transportation to a new residence or facility, are available upon transfer or discharge.

(D) Helping prepare the resident for the move to a new residence or facility by appropriate methods, including trial visits.

(E) Thoroughly informing staff at the receiving residence or facility about the resident's needs, strengths, routines, relationships, and preferences.

~~SEC. 7. Section 14124.10 of the Welfare and Institutions Code is amended to read:~~

~~14124.10. (a) No licensed long-term health care facility participating as a provider under the Medi-Cal program shall discriminate against a Medi-Cal resident or prospective Medi-Cal resident on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program. Nothing in this section shall be construed to prohibit a facility from charging private-pay residents for services required to be provided to Medi-Cal residents or which are in addition to those required under the Medi-Cal program.~~

~~(b) For purposes of this section, the following definitions shall apply:~~

~~(1) "Skilled nursing facility" means a licensed facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code.~~

~~(2) "Exempt facility" means a skilled nursing facility that is part of a continuing care retirement community as defined in Section 1771 or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.~~

~~(c) A skilled nursing facility certified for participation in the Medi-Cal program that is not an exempt facility shall not discriminate on the basis of source of payment against a current or prospective Medi-Cal beneficiary who seeks admission. Except as otherwise provided by law or as specified in subdivision (d), all applicants for admission shall be admitted in the order in which they first request admission. Each skilled nursing facility shall do all of the following:~~

~~(1) Provide a copy of the notice described in paragraph (4) to each person who requests information about admission.~~

~~(2) Provide to each person seeking admission a receipt recording the date and time of the request.~~

~~(3) Maintain a dated list of applications that shall be available at all times to any applicant, his or her legal representative, and authorized personnel from the department. If a skilled nursing facility desires to remove the name of an applicant who is unresponsive to facility telephone calls and letters from its waiting list, the skilled nursing facility may, no sooner than 90 days after initial placement of the person's name on the waiting list, inquire by letter to that applicant and any one person if designated by that applicant whether the applicant desires continuation of his or her name on the waiting list. If the applicant does not respond and an additional 30 days passes, the facility may remove the applicant's name from its waiting list. A skilled nursing facility may annually send a waiting list placement continuation letter to each person who has been on the waiting list for at least 90 days to inquire as to whether that person desires continuation of his or her name on the waiting list if that letter is also sent to any one person designated by the applicant. If an applicant to whom the letter was sent does not respond and at least 30 days passes, the facility may remove the person's name from its waiting list.~~

~~(4) Post in a conspicuous place a notice in plain language informing persons seeking admission that the facility is prohibited from discriminating against applicants for admission on the basis of their current or future Medi-Cal eligibility. The notice shall advise persons seeking admission about the facility's application procedures and describe the complaint options and remedies available under this section. The notice shall also list the name, address, and telephone number of the local office of the State Long-Term Care Ombudsman.~~

~~(d) Notwithstanding the requirements of subdivision (c), a skilled nursing facility may disregard its waiting list to admit an applicant whose spouse is a current resident of the facility or to admit a person who lives within a retirement community located on the same campus as the skilled nursing facility. Residents of the skilled nursing facility who are hospitalized or away from the facility on authorized leaves shall not be subject to the waiting list and shall be readmitted in accordance with state and federal laws, including the rights provided under subdivision (h) of Section 1599.1 of the Health and Safety Code.~~

~~(e) Upon the receipt of a complaint concerning a violation of this section, the department shall conduct an investigation into the complaint in accordance with Section 1420 of the Health and Safety Code.~~

~~(f) The department may decrease the daily Medi-Cal reimbursement rate to a long-term health care facility for one year for a violation of this section. The per diem rate shall be reduced by one-quarter of 1 percent for an initial violation of this section and 1 percent for each additional violation.~~

SEC. 7. Section 14124.10 of the Welfare and Institutions Code is amended to read:

14124.10. *(a)* No licensed long-term health care facility participating as a provider under the Medi-Cal program shall discriminate against a Medi-Cal ~~patient~~ *resident or prospective Medi-Cal resident* on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program. Nothing in this section shall be construed to prohibit a facility from charging private-pay ~~patients~~ *residents* for services required to be provided to Medi-Cal ~~patients~~ *residents* or ~~which~~ *for services that* are in addition to those required under the Medi-Cal program. ~~This section applies to licensed long-term health care facilities, to the extent not prohibited by federal law.~~

(b) For purposes of this section, the following definitions shall apply:

(1) "Skilled nursing facility" means a licensed facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code.

(2) "Exempt facility" means a skilled nursing facility that is part of a continuing care retirement community as defined in Section 1771 or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.

(c) A skilled nursing facility certified for participation in the Medi-Cal program that is not an exempt facility shall not discriminate on the basis of source of payment against a current or prospective Medi-Cal beneficiary who seeks admission. Except as otherwise provided by law or as specified in subdivision (d), all applicants for admission shall be admitted in the order in which they first request admission. Each skilled nursing facility shall do all of the following:

(1) Provide a copy of the notice described in paragraph (4) to each person who requests information about admission.

(2) Provide to each person seeking admission a receipt recording the date and time of the request.

(3) Maintain a dated list of applications that shall be available at all times to any applicant, his or her legal representative, and authorized personnel from the department. If a skilled nursing facility desires to remove the name of an applicant who is unresponsive to facility telephone calls and letters from its waiting list, the skilled nursing facility may, no sooner than 90 days after initial placement of the person's name on the waiting list, inquire by letter to that applicant and any one person if designated by that applicant whether the applicant desires continuation of his or her name on the waiting list. If the applicant does not respond and an additional 30 days passes, the facility may remove the applicant's name from its waiting list. A skilled nursing facility may annually send a waiting list placement continuation letter to each person who has been on the waiting list for at least 90 days to inquire as to whether that person desires continuation of his or her name on the waiting list if that letter is also sent to any one person designated by the applicant. If an applicant to whom the letter was sent does not respond and at least 30 days passes, the facility may remove the person's name from its waiting list.

(4) Post in a conspicuous place a notice in plain language informing persons seeking admission that the facility is prohibited from discriminating against applicants for admission on the basis of their current or future Medi-Cal eligibility. The notice shall advise persons seeking admission about the facility's application procedures and describe the complaint options and remedies available under this section. The notice shall also list the name, address, and telephone number of the local office of the State Long-Term Care Ombudsman.

(d) Notwithstanding the requirements of subdivision (c), a skilled nursing facility may disregard its waiting list to admit an applicant whose spouse is a current resident of the facility or to admit a person who lives within a retirement community located on the same campus as the skilled nursing facility. Residents of the skilled nursing facility who are hospitalized or away from the facility on authorized leaves shall not be subject to the waiting

list and shall be readmitted in accordance with state and federal laws, including the rights provided under subdivision (h) of Section 1599.1 of the Health and Safety Code.

(e) Upon the receipt of a complaint concerning a violation of this section, the department shall conduct an investigation into the complaint in accordance with Section 1420 of the Health and Safety Code.

SEC. 8. Section 14126.023 of the Welfare and Institutions Code is amended to read:

14126.023. (a) The methodology developed pursuant to this article shall be facility specific and reflect the sum of the projected cost of each cost category and passthrough costs, as follows:

(1) Labor costs limited as specified in subdivision (c).

(2) Indirect care nonlabor costs limited to the 75th percentile.

(3) Administrative costs limited to the 50th percentile.

(4) Capital costs based on a fair rental value system (FRVS) limited as specified in subdivision (d).

(5) Direct passthrough of proportional Medi-Cal costs for property taxes, facility license fees, new state and federal mandates, caregiver training costs, and liability insurance projected on the prior year's costs.

(b) The percentiles in paragraphs (1) through (3) of subdivision (a) shall be based on annualized costs divided by total resident days and computed on a specific geographic peer group basis. Costs within a specific cost category shall not be shifted to any other cost category.

(c) The labor costs category shall be comprised of a direct resident care labor cost category, an indirect care labor cost category, and a labor-driven operating allocation cost category, as follows:

(1) Direct resident care labor cost category which shall include all labor costs related to routine nursing services including all nursing, social services, activities, and other direct care personnel. These costs shall be limited to the 90th percentile.

(2) Indirect care labor cost category which shall include all labor costs related to staff supporting the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, inservice education, and plant

operations and maintenance. These costs shall be limited to the 90th percentile.

(3) Labor-driven operating allocation shall include an amount equal to 8 percent of labor costs, minus expenditures for temporary staffing, which may be used to cover allowable Medi-Cal expenditures. In no instance shall the operating allocation exceed 5 percent of the facility's total Medi-Cal reimbursement rate. The labor-driven operating allocation shall not be paid to facilities that, on an annual basis, fail to comply with the minimum staffing requirements established pursuant to Section 1276.5 of the Health and Safety Code.

(d) The capital cost category shall be based on a FRVS that recognizes the value of the capital related assets necessary to care for Medi-Cal residents. The capital cost category includes mortgage principal and interest, leases, leasehold improvements, depreciation of real property, equipment, and other capital related expenses. The FRVS methodology shall be based on the formula developed by the department that assesses facility value based on age and condition and uses a recognized market interest factor. Capital investment and improvement expenditures included in the FRVS formula shall be documented in cost reports or supplemental reports required by the department. The capital costs based on FRVS shall be limited as follows:

(1) For the 2005–06 rate year, the capital cost category for all facilities in the aggregate shall not exceed the department's estimated value for this cost category for the 2004–05 rate year.

(2) For the 2006–07 rate year and subsequent rate years, the maximum annual increase for the capital cost category for all facilities in the aggregate shall not exceed 8 percent of the prior rate year's FRVS cost component.

(3) If the total capital costs for all facilities in the aggregate for the 2005–06 rate year exceeds the value of the capital costs for all facilities in the aggregate for the 2004–05 rate year, or if that capital cost category for all facilities in the aggregate for the 2006–07 rate year or any rate year thereafter exceeds 8 percent of the prior rate year's value, the department shall reduce the capital cost category for all facilities in equal proportion in order to comply with paragraphs (1) and (2).

(e) For the 2005–06 and 2006–07 rate years, the facility specific Medi-Cal reimbursement rate calculated under this

article shall not be less than the Medi-Cal rate that the specific facility would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005–06 and 2006–07, respectively.

(f) The department shall update each facility specific rate calculated under this methodology annually. The update process shall be prescribed in the Medicaid state plan, regulations, and the provider bulletins or similar instructions described in Section 14126.027, and shall be adjusted in accordance with the results of facility specific audit and review findings in accordance with subdivisions (h) and (i).

(g) The department shall establish rates pursuant to this article on the basis of facility cost data reported in the integrated long-term care disclosure and Medi-Cal cost report required by Section 128730 of the Health and Safety Code for the most recent reporting period available, and cost data reported in other facility financial disclosure reports or supplemental information required by the department in order to implement this article.

(h) The department shall conduct financial audits of facility and home office cost data as follows:

(1) The department shall audit facilities a minimum of once every three years to ensure accuracy of reported costs. Audits shall examine the accuracy of payroll records described in subdivision *(l)*. Fraudulently reported labor costs shall be subject to all of the following:

(A) Referral to the Franchise Tax Board and Internal Revenue Service for investigation.

(B) Recovery of overpayments through a retroactive adjustment of the facility specific reimbursement rate.

(C) Assessment of a penalty equal to 200 percent of the fraudulently reported direct care staffing hours times the average hourly wage of the direct care staff at the time the fraudulent activity occurred.

(2) It is the intent of the Legislature that the department develop and implement limited scope audits of key cost centers or categories to assure that the rate paid in the years between each full scope audit required in paragraph (1) accurately reflects actual costs.

(3) For purposes of updating facility specific rates, the department shall adjust or reclassify costs reported consistent with applicable requirements of the Medicaid state plan as required by Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations.

(4) Overpayments to any facility shall be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations.

(i) (1) On an annual basis, the department shall use the results of audits performed pursuant to subdivision (h), the results of any federal audits, and facility cost reports, including supplemental reports of actual costs incurred in specific cost centers or categories as required by the department, to determine any difference between reported costs used to calculate a facility's rate and audited facility expenditures in the rate year.

(2) If the department determines that there is a difference between reported costs and audited facility expenditures pursuant to paragraph (1), the department shall adjust a facility's reimbursement prospectively over the intervening years between audits by an amount that reflects the difference, consistent with the methodology specified in this article.

(j) For nursing facilities that obtain an audit appeal decision that results in revision of the facility's allowable costs, the facility shall be entitled to seek a retroactive adjustment in its facility specific reimbursement rate.

(k) Compliance by each facility with state laws and regulations regarding staffing levels shall be documented annually either through facility cost reports, including supplemental reports, or through the annual licensing inspection process specified in Section 1422 of the Health and Safety Code.

(l) For purposes of documenting labor costs described in subdivision (c), a skilled nursing facility shall submit electronic payroll records to the department on a quarterly basis. Under penalty of perjury, the administrator of the facility shall sign and certify the accuracy of the payroll records. On or before July 1, 2006, the department shall devise and implement a uniform system for collecting and evaluating payroll data.

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school

district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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